NATIONAL LATINO COUNCIL
ON ALCOHOL AND TOBACCO PREVENTION

Health Disparities Impacting the Latino Community— This Is Not a Time to Go Backwards on Civil Rights

Katherine Culliton, Esq., LCAT Policy Director
March 1, 2006

Executive Summary:

This paper discusses the severe health disparities impacting the Latino community, which have become exacerbated post-Katrina, then analyzes the various public policy challenges and reforms needed to protect Latino community health. In particular, (1) language access, (2) services for immigrant families, and (3) continued protections against race/ethnic discrimination, are essential elements for addressing health disparities and their grave consequences for millions of Latino families. LCAT's experience in the field is utilized as an example as to why such civil rights protections are essential. The paper compares two very different health disparities models being debated on Capitol Hill, analyzes these models, and concludes that only the model with essential civil rights protections would be viable and effective. The paper discusses that any model that does not include such protections would take America **backwards** in terms of civil rights. Moreover, failure to include these essential protections would **not** be effective and may even exacerbate the health disparities negatively impacting the Latino community. The Latino community is not only the youngest, largest, and fastest-growing race/ethnic "minority" in the United States. Despite its economic contribution, the Latino community is also the group that experiences the harshest health disparities. For all these reasons, LCAT urges policy-makers to enact health disparities legislation that includes the essential civil rights protections discussed herein.

A. Introduction:

The reality of structural disparities experienced by people of color suddenly became apparent to many Americans who saw the devastating impact of *Hurricane Katrina* on the national news last August 29th and thereafter. Post-Katrina, an October 27th *New California Media* (NCM) poll of the major racial and ethnic groups in the

United States found that African Americans and Latinos agreed that, "There is a lot more racism in the United States than I ever imagined," while non-Hispanic Whites disagreed with the statement, and Asians were evenly divided. The NCM poll also showed that the majority of all surveyed agreed that "eliminating poverty in our country" is an important public policy priority. Simultaneously, a new national debate about disparities prompted renewed interest in legislation to close the severe health disparities gaps in the U.S. Although the majority of those affected by Katrina are African Americans, many Native Americans, Asian Americans, and Latinos, including Afro-Latinos, also lost their homes, their livelihood, and family members. Latinos are also among the tens of thousands struggling to find adequate health care post-Katrina, and the structural disparities are particularly harsh for Latino immigrant families. Post-Katrina, long-standing structural disparities impacting the Latino community have been exacerbated, demonstrating that any policy initiatives designed to redress health disparities must take into account the factors causing severe health disparities in the Latino community.

Latinos seeking post-Katrina relief services have been unduly required to produce information about their immigration status. As 68% of Latinos are either immigrants (40%) or children of immigrants (23%), many Latino families in Louisiana and Mississippi have been affected by these harsh new policies (Suros and Passel, 2003). According to Kari Lydersen's September 28, 2005, article in *The New Standard*, Katrina affected an estimated 300,000 immigrants, mostly Central Americans and Mexicans. As will be discussed herein, not only Latino immigrants, but also their family members, suffer severe health disparities due to policies that restrict immigrants' access to public benefits. Moreover, such policies disparately impact the Latino community.

Both law and practice have traditionally required the *Federal Emergency Management Agency* (FEMA) to refrain from asking about immigration status. For

example, after 9/11, FEMA issued public statements reassuring immigrant families that they should apply for benefits and should not be concerned about immigration repercussions (FEMA, *All Who Need Help Should Seek Help Regardless of Immigration Status*, 2001). During the 2004 hurricane season, while Tom Ridge was Secretary of Homeland Security, FEMA did not ask about immigration status and did not participate in immigration enforcement. Now, national Latino groups have called on Homeland Security Secretary Michael Chertoff to suspend deportation proceedings against immigrants seeking assistance in the wake of Katrina (NCLR and LULAC, 2005). Thus, with Katrina, there was a sudden policy turnabout to restrict emergency relief benefits for immigrant families. No rationale was offered for the sudden policy shift.

Unfortunately, the new FEMA practice was continued in Florida after November's *Hurricane Rita*, with a severe impact on the Mexican migrant farm workers, who lost their subsistence wages and are now confronting numerous challenges. As hard-working Latino immigrants confront challenges to their health and well-being when disasters occur in the United States, many are not only less protected than other communities, they are now also unfairly denied the emergency aid relief that everyone deserves.

Just after Katrina struck here in the U.S., *Hurricane Stan* struck Central America, causing tens of thousands of deaths in El Salvador, Guatemala, and Southern Mexico. The communities hit hardest were Mayan, particularly in Guatemala, where millions were affected and over 100,000 people are living in shelters and makeshift camps. Since Mayan communities in Guatemala were most affected by previous political and economic crises in Central America, they were the most vulnerable. For example, in the Mayan settlement near *Lake Atitlán*, an important historical site, all 1,400 residents lost their

lives in mudslides, as their lands had been stolen and they lived in shacks in the most dangerous, precarious areas (CARECEN, 2005).

Despite the impact of natural disasters throughout Central America, the Government of Guatemala has never requested *Temporary Protective Status* (TPS), which has been granted to other Central American nationals in order to help them work legally in the U.S. and send remittances to their countries of origin to assist in recovery efforts. According to international economic institutions such as the *World Bank* and the *Inter-American Development Bank*, remittances have become an essential form of foreign aid for Latin America (IADB, 2005). Because Latin America receives less U.S. aid than any other region of the world, remittances are especially critical, and many Latino families send remittances to their loved ones in Latin America, leaving less income available for them in the U.S.

After *Hurricane Stan* in November, Guatemala finally requested TPS, and advocates around the country are also urging the Administration to finally provide TPS to Guatemalans, although it has yet to be provided. Their request cuts to the heart of disparities that impact many Central American families—it would lift many Guatemalan American families out of severe poverty and related abysmal health conditions. However, as will be discussed herein, TPS does not provide equal access to health. In fact, since the 1996 immigration and welfare reforms, even *Legal Permanent Resident* (LPR) status does not permit equal access to health. Therefore, any health disparities bill must redress the inequities caused by current U.S. immigration law.

Race/ethnic discrimination is another major factor causing health disparities in the Latino community. As will be discussed herein, race/ethnic discrimination is a predominant cause of the disparate treatment experienced by the nation's diverse Latino community. Any bill that intends to resolve health disparities must address and redress

race/ethnic discrimination head-on. Furthermore, health disparities legislation must address the intersectionality of various forms of discrimination, *e.g*., discrimination based on other factors (gender, socioeconomic status, sexual orientation, etc.), combined with race/ethnic discrimination. However, funding and programs designed to redress race/ethnic discrimination must not be diluted in the process.

A third major cause of health disparities for the Latino community is the failure to provide appropriate language services for those who cannot access services in English. Most Latinos speak English, and Latino immigrants are learning English at faster rates than historical U.S. immigrant groups. However, due in part to cutbacks in lack of *English as a Second Language* (ESL) programs, many Latino immigrants either do not speak English or are not yet sufficiently fluent to navigate the complex public health system in English. On August 11, 2000, *Executive Order 13166* recognized that failure to provide language access may constitute "national origin discrimination" under Title VI of the *1964 Civil Rights Act*. Therefore, *Executive Order 13166* required that all federally-funded programs must take steps to provide "meaningful access" to their programs and activities to limited English proficiency (LEP) persons (*Exec. Order 13166*, 2000). Despite this legal requirement, many federally-funded programs still do not provide adequate translation or access to their programs in Spanish, and many Latinos have been unable to access disaster relief benefits, including critical health services, due to failure to provide for language access.

This introduction began with a discussion of Katrina, and one cannot negate the devastating impact of structural disparities pre- and post-Katrina on the African American community. At the same time, a similarly harsh, parallel reality is holding back Latinos, especially Latino immigrant families, who are affected by similar structural disparities. Latino public health experts and advocacy groups such as the *National Latino Council for*

Alcohol and Tobacco Prevention (LCAT) are highly aware of the actual disparities that affect communities of color. We have learned from tough experience that structural disparities impede our mission of improving community health. The post-Katrina context has exacerbated these long-standing disparities, and it is time to redress them.

B. Public Policy Challenges. Various health disparities bills have been proposed in the current Congress, including two major bills that reflect the current public policy debate. The first is the *Healthcare Equality and Accountability Act* (hereinafter "Healthcare Equality Act"), S. 1580, sponsored by Senator Daniel Akaka (D. -HI.), with 18 Democratic co-sponsors in the Senate, and its companion bill, H.R. 3561, sponsored by Rep. Michael M. Honda (D. -CA.), with 113 Democratic co-sponsors in the House, including most members of the *Congressional Hispanic Caucus*. The second is the *Closing the Health Care Gap Act of 2004* (hereinafter "Closing the Health Care Gap Act"), former S. 2091, introduced by Senator William Frist (R. -TN.) with eight bipartisan co-sponsors in 2004, which, at the time of this publication, is expected to be reintroduced in the near future. As will be demonstrated below, in order to effectively address health disparities in the U.S. today, legislative remedies must effectively address race/ethnicity, language access, and immigration status; otherwise, any health disparities legislation will leave out the Latino population. Each of these critical factors will be discussed in turn below, and the health disparities bills will be analyzed to determine whether they would be effective with regard to the essential needs of the Latino community.

1. Immigration Status Disparities. In order to redress the health disparities experienced by about two-thirds of the nation's Latino community, new health disparities legislation must include provisions providing access to health care for immigrants. The *Health Care Equality Act* provides immigrants' access to health care (Title C), whereas

the *Closing the Health Care Gap Act* does not (S. 2091, *passim*.). According to the 2000 census, 9.9 million Latinos (28% of Latino population) are 2nd generation (native-born, with at least one foreign-born parent), and 14.2 million Latinos (40% Latino population) are 1st generation (foreign-born). In total, 24.1 million Latinos (68% Latino population) are either immigrants or have a parent who is an immigrant (Pew Hispanic, 2003). Latino immigrants have few options, as the path to citizenship, which may confer access to public health benefits, has become more difficult in recent years. Due to increasingly prohibitive costs, and new educational requirements, including essay examinations in English, which exceed U.S. high school standards, among other factors, very few Latino immigrants become U.S. citizens (NHLA, 2004, 23-24). In addition, many Latino immigrants' U.S. citizen family members are also negatively impacted by restrictions on immigrant access to health care. As discussed below, none of the possible immigration statuses provide equal access to health care; therefore, any health disparities legislation that does not remedy these inequities will leave out the majority of Latinos.

Some Central American immigrants have been able to access *Temporary Protective Status* (TPS). TPS was provided to certain immigrants from El Salvador and Honduras after *Hurricane Mitch* in 1998, and it was provided to El Salvadorans who had been discriminated against in their asylum applications. TPS and most other temporary immigration statuses generally do not permit receiving any sort of public benefits, unless the temporary visa holder is one of the lucky few who are conditionally awaiting political asylum or refugee status, which will eventually convert to LPR status (Broder, 2005). Many Central Americans have had access to only temporary, not permanent, immigration status, even when a class-action lawsuit proved that they had been denied political asylum through INS discrimination (*American Baptist Churches v. Thornburg*, 1991).

All of this falls upon a backdrop of a dysfunctional immigration system, in which few Latino immigrants can achieve *Legal Permanent Resident* (LPR) status. The broken immigration system includes 14-year backlogs for "first-priority" legal immigration for deserving Mexican American families. These and other malfunctions have a disparate impact on the Latino community (NHLA, 2004).

Latino immigrants who are "out-of-status" have relatively little if any access to health care, and current immigration reform proposals would not resolve this problem. As reported on November 28th in the *Associated Press*, with regard to the current undocumented population, most of whom are Mexican immigrants, President Bush's guest worker proposal would keep them in a temporary status, therefore still barred from receiving any public benefits. Historically, the fact that Mexican migrants have been relegated to guest worker status through the *bracero* program and through current temporary worker programs, has led to declining socio-economic status, including less access to health (Rep. Conyers, 2000).

Even those Latino immigrants able to achieve LPR status have restricted access to health care. The 1996 immigration and welfare law reforms embodied in the *Personal Responsibility and Work Opportunity Reconciliation Act* banned even LPRs from receiving benefits from any federally-funded program during the early years of their residency (*Personal Responsibility and Work Opportunity Reconciliation Act*, 2005). Recent state initiatives are also blocking immigrant access to services at the state level. For example, since the enactment of Proposition 200 in November 2004 in Arizona, copycat initiatives are being introduced or planned in at least seven other states (Protect America Now, 2005). Under these new state initiatives, as well as under the federal rules and practices limiting immigrant access to health care, immigrants as well as their family members experience severely reduced access to health (Broder, 2005). This is because

not only immigrant family members, but also their U.S. citizen relatives, fear immigration consequences when seeking public benefits (NHLA, 2004). Children are particularly affected, as U.S. citizen children cannot access public benefits if their parents fear immigration consequences and therefore cannot approach the government (Id. and *Friendly House v. Napolitano,* 2005). Under these circumstances, public health initiatives designed to remedy the severe health disparities experienced by the Latino community, which have been exacerbated post-Katrina, cannot be resolved if the systemic challenges experienced by Latino immigrant families are not redressed (*see, e.g.,* Dr. Robinson, 2005)(discussing comprehensiveness).

The current system makes it difficult for groups like LCAT to complete the mission of protecting the Latino community's health. For example, critical federally-funded health initiatives, such as the U.S.-Mexican government-sponsored *Border Health Initiative*, do not reach immigrants and their families. LCAT participates in the *Border Health Initiative*, in order to provide information about prevention and treatment programs, public education, and technical assistance to local community groups. LCAT also provides anti-tobacco and alcohol abuse prevention materials in Spanish, to reach Spanish-speaking members of the Latino community. However, due to U.S. government restrictions on immigrants' access to health care, LCAT and other members of the non-profit sector, which have limited resources, must also work independently to try to reach those millions of Latino families the government is not helping.

In sum, as long as U.S.-government-sponsored programs do not provide outreach to Latino immigrants, Spanish-language materials about the dangers of smoking and alcohol abuse will not be distributed effectively through these programs. LCAT is extremely concerned about the health of Latino immigrants, because recent studies show

that although they arrive smoking and abusing alcohol *less* than other groups, upon acculturation to the United States, rates of smoking and alcohol abuse rise sharply, causing serious damage to individual, family, and community health (Falcón, Aguirre-Molina & Molina, 2001, 14-15)(HHS Surgeon General, 1988).

For all these reasons, Latino public health advocates favor a health disparities bill that would loosen or otherwise compensate for the unwise restrictions set in place through the 1996 immigration and welfare law reforms. In particular, LCAT favors the *Healthcare Equality Act* precisely because it permits immigrants to receive federal *Medicare and Family Care Benefits* (Title C). By remedying this structural disparity at the federal level, the new health disparities legislation could also pave the way to end discrimination in public health settings at the state level as well. Immigrants actually pay more taxes, and use less benefits, than U.S. citizens (Fix and Passel, 2001), yet many Latino families headed by hard-working immigrants have suffered health disparities due to the harsh impact of the 1996 immigration and welfare law reforms and their impact at the state level (Fremstad and Cox, 2004). Moreover, no conflict of law that would prohibit policy-makers from remedying the inequities caused by the 1996 reforms, and in fact failure to provide immigrant access to emergency health care could be unconstitutional (*Friendly House v. Napolitano*, 2005; *LULAC v. Wilson*, 1985).

Like other national Latino groups, LCAT also calls on FEMA and all agencies of the federal government who provide health or relief aid to refrain from asking about immigration status. As discussed above, the health of about 68% of the Latino community is at stake, as 40% are immigrants another 28% are children of immigrants (Pew Hispanic, 2003). Their lack of access will not be resolved without appropriate legal and policy reforms. For those members of the Latino community affected by natural disasters, these issues are even more critical. As policy-makers consider the need for

health disparities legislation, they should consider that it is unconscionable that hard-working, deserving Latino immigrant families are being denied the basic health care they need to survive. Unless the underlying policies causing such health disparities are reformed, many Latino families will be left out.

2. <u>Race/Ethnic Disparities</u>. Any health disparities bill that hopes to close the severe gap in access to health experienced by the nation's Latino community must address race/ethnic discrimination. This is because many, if not all, of the actual forms of health disparities experienced by Latinos can be traced to race/ethnic discrimination. The *National Health Disparities Report* conducted by the *Office of Minority Health* (OMH) of the *Department of Health and Human Services* demonstrated that race/ethnicity is directly linked with health disparities, and that such health disparities do not vary with income (OMH, 2003 and 2004). The OMH found that upper-class Latinos were treated worse than upper-class whites, and low-income Latinos were treated worse than low-income whites. In other words, in the United States today, many health care providers perceive who is a "minority" and provide "minorities" with worse health care than others (Giachello, 1996 and 2005). Furthermore, according to the OMH, in 2000 and 2001, "Hispanics received lower quality care than non-Hispanic whites for half of quality measures and had worse access to care than non-Hispanic whites for about 90% of access measures." (OMH, 2004, *Disparities Are Pervasive*, 6). The *National Health Disparities Report* proves that the color of one's skin, an "accent," or a Hispanic surname, can and do lead to health disparities in the U.S.

The immigration status issues and concurrent obstacles to health equality described above are also related to race/ethnic discrimination. The majority of U.S. immigrants today are Latinos, and at least 68% of nation's more than 40 million Latinos are impacted by measures restricting immigrants' access to health. Furthermore, an

openly anti-Latino immigrant climate fuels the laws and policies restricting immigrants' access to health, demonstrating that not only a disparate impact but also a more direct form of discrimination is at issue (Huntington, 2004; MALDEF and LULAC, 2004). To redress statutory discrimination, the *Immigration and Nationality Act* (INA) was the first statute amended after the enactment of the *1964 Civil Rights Act*. As the INA included a pervasive scheme of discrimination, it was actually the first statute amended after enactment of the *1964 Civil Rights Act* (Senator Kennedy, 1965). Since then, although direct, statutory discrimination has been eliminated, discrimination in the implementation of immigration law has not (*U.S. Commission on Civil Rights*, 1980, 1989 and 1993). For example, Mexican immigrants must endure a 14-year waiting period for "first priority" legal family reunification, while the wait is less than a year for European immigrants (NHLA, 2004). Also, a disproportionate number of immigration enforcement actions have been directed against Latinos, at the border, in airports, and otherwise (Wishnie, 2004.) Moreover, since 9/11, groups tied with White Supremacy organizations have fueled an onslaught of anti-immigrant laws and other anti-immigrant public policy initiatives directed at Latinos (Scherer, 2005; SPLC, 2005). As discussed, these discriminatory policies block Latino immigrants' and their families' access to health care in the United States. Moreover, post-Katrina and post-Rita, Latinos, but not other communities are being made to produce information about immigration status to access hurricane relief programs. Even those Latinos who are U.S. citizens are being harassed to produce immigration status information, demonstrating that all Latinos may be perceived as immigrants and thereby treated in a discriminatory manner due to race/ethnic factors.

Race/ethnic discrimination also results in diminishing socio-economic status across-the-board, which creates further health disparities for Latinos. For example, as reported by the *Associated Press* last year, Latino construction workers in the United

States suffer the highest rates of on-the-job injuries, due to discriminatory working conditions and lack of *Department of Labor* (DOL) oversight. In the Southwest, the rate of injuries for Latino construction workers is three times the rate of injuries for their white counterparts. Some have argued that these unconscionable working conditions are due to lack of immigration status among many Latino construction workers. However, race/ethnic discrimination is shown by the fact that not only immigrant construction workers suffer a higher injury rate, but also all Latinos, including those who are U.S. citizens, working in the construction sector suffer the same differential rate of injuries (Culliton, 2005).

Race/ethnic discrimination is also behind the DOL failure to protect Latinos' fundamental labor rights. The *Associated Press* reported that the DOL said that the agency did not have the language skills to do so; however, this is not a valid excuse under civil rights law (*Executive Order 13166*, 1.) The DOL is not only negligent with regard to monitoring and enforcing Latino workers' rights. As reported by Brendan Coyne in the July 13th edition of *The New Standard*, the DOL has also directly discriminated by announcing worker safety and workers' rights sessions to be held in Spanish, then facilitating immigration status checks and deportation proceedings among the unlucky attendees. The *National Council of La Raza* (NCLR) reported in a November 22nd news release that similar problems continue post-Katrina, as Latino workers lending their skills and labor to the reconstruction efforts have experienced yet another egregious pattern of labor rights violations that the DOL has yet to investigate. In sum, being part of the Latino construction labor market severely impacts access to health, through increased health risks, on jobs that do not provide health insurance or sufficient income to purchase health care for Latino construction workers and their families.

These are just a few examples of race/ethnic discrimination leading to health disparities experienced by Latinos. Furthermore, race/ethnic health disparities have a negative public health outcome for nearly everyone, as the modern United States is an increasingly diverse society. If the severe health disparities experienced by the nation's young, growing Latino population are not redressed, a number of public health crises are predictable. The *Health Care Equality Act*, which LCAT supports, would directly address such race/ethnic disparities, as its purpose is "to improve the health and healthcare of minority populations and to eliminate racial and ethnic disparities in health and health care." (Sec. 2, *Health Care Equality Act*). In contrast, the purpose of the *Closing the Health Care Gap Act* is not directly stated, but the scope of its provisions includes not only "racial and ethnic minorities," but also "other health disparity populations." (Sec. 2, *Closing the Health Care Gap Act*). This is based on certain Congressional findings that:

> [T]he health care delivery system has not been able to provide consistently high quality care to all Americans; data collection, analysis, and reporting by race, ethnicity, and primary language are essential for eliminating health disparities; the largest numbers of medically underserved are white individuals (i.e., Appalachia), and many of them have the same health care access problems as do members of minority groups; however, there is a higher proportion of racial and ethnic minorities in the U.S. represented among the medically underserved; additional research is needed in order to understand the causes of disparities and develop effective approaches to eliminate these gaps in health care quality; and there is a need to ensure appropriate representation of racial and ethnic minorities, and other health disparity populations, in the health care professions. (Id.)

The above reasoning is circular. While it is true that some white individuals are affected by health disparities, this is because they experience disparities as rural persons. However, Latinos are also highly represented among rural populations who experience health disparities due to their rural status. Also, racial and ethnic minorities are disproportionately impacted by lack of access to health, while whites are not disparately impacted.

Similarly, while white construction workers work in one of the most dangerous professions, they enjoy much better safety protections than similarly-situated Latino construction workers. White immigrants are also impacted by anti-immigrant policies, but not disproportionately, and in fact white immigrants have a much easier time than others. It is also true that non-Hispanic whites enjoy disproportionately greater access to health care than all other racial and ethnic groups.

Distinguishing the two legislative schemes is critical, because one will improve race/ethnic disparities, while the other could even exacerbate them. The *Closing the Health Care Gap Act* would direct assistance to "other health disparity populations," which is a laudable goal. The problem lies in that it would also dilute legislative mandates and funding away from closing the minority health care gap. For example, the *Office of Minority Health* would be forced to use some of its already-scarce resources to address rural and gender health care gaps, along with servicing whatever other non-minority "health disparities populations" might be identified under the legislative scheme in the future (Sec. 1, *Closing the Health Care Gap Act*). Considering that there already exists an office of women and health and a rural health department of the *Department of Health and Human Services* (HHS), a collaborative solution would be more in order.

Comparing the two legislative schemes, the *Healthcare Equality Act* also recognizes that other forms of discrimination, in addition to race/ethnic discrimination, may also lead to health disparities. The main distinction is that the equality-based bill would not dilute the essential work of resolving race/ethnic discrimination. Instead, this legislative scheme would simultaneously address other forms of discrimination that lead to health care disparities, without diluting funding for critical race/ethnic-based remedies and programs, such as the *Office of Minority Health* (OMH). Under the *Healthcare Equality Act*, the OMH would cooperate with the departments addressing rural and

gender health disparities, and take the lead in studying and remedying race/ethnic health disparities. The *Healthcare Equality Act* would also have the OMH take into account the reality of gender, rural status, disability, and other types of discrimination experienced by people of color (Sec. 1 *et. al., Health Care Equality Act*). Recognizing various forms of discrimination is essential, because without taking into account the complexity of the reality of health disparities in communities of color, such disparities will not be fully resolved (Dr. Robinson, 2005). The critical difference between the *Healthcare Equality Act* and the *Closing the Healthcare Gap Act* is that the equality-based act would not dilute funding and programs addressing race/ethnic disparities, whereas the gap-based act would divert funding and legislative mandates from race/ethnic programs to address the fact that "the largest numbers of medically underserved are white individuals (i.e., Appalachia)." (Sec. 1, *Closing the Healthcare Gap Act*, 2004).

The equality-based bill is more comprehensive and better matches reality by encompassing the concept of the intersectionality of discrimination. The intersectionality of discrimination simply means that individuals and communities can and do experience not one, but various, types of discrimination. When various forms of discrimination are compounded, this contributes to an even harsher disproportionate impact of health disparities. For example, a Puerto Rican woman may experience health disparities both because of her status as a woman (due to gender discrimination) and as a Latina (due to race/ethnic discrimination). If only one of these factors is addressed, her health disparities will not be fully remedied. She may be receiving less access to federal benefits because Puerto Rico is not properly reimbursed for federal expenditures, and because health care providers who treat her may make stereotypical assumptions about Latinos. She may also be of African descent, and so may experience additional, heightened race/ethnic discrimination. In addition, due to gender discrimination, she is

likely to be treated worse than men. Rather than suffering from only one form of discrimination, she may be exposed to compounded discrimination, which the legal system must take into account if it is to effectively protect her rights to equality and resolve the discriminatory conditions of her life (Romany and Culliton, 2002). This mirrors the community development model recommended by Dr. Robert Robinson, who recently retired from the *Centers for Disease Control* (CDC) *Office of Smoking and Health* (OSH) after many years of service. Dr. Robinson recommends health access programs that take into account the diversity and complex reality of the lives of communities of color, without losing sight of the fact that people of color experience race/ethnic discrimination (Robinson, 2005). This type of program provides a viable means for closing various health care gaps without creating more disparities and/or leaving some people behind. Along these lines, the equality-based bill includes a section improving programs and funding to remedy rural health disparities, which would address the needs of white Appalachians, and provide extensive programmatic attention to remedying rural health disparities. However, as a reality-based and equality-based model, the *Healthcare Equality Act* would also provide rural "race/ethnic minorities" with protections against race/ethnic discrimination *(Sec. 399O, Healthcare Equality Act)*.

The concept of intersectionality is particularly important for the nation's 40 million Latinos, because "Latinos" are an extremely diverse group. Many Latinos have less access to health due to their status as indigenous peoples, as Afro-Latinos, as Asian or Jewish Latinos, for example, or due to socioeconomic status, and/or as rural people. As mentioned above, Latinos are overly-represented in U.S. rural communities, and experience health disparities based upon that status. Latinos also comprise over 90% of agricultural workers, who experience some of the most extreme health disparities in the United States today.

Considering the current backlash against Mexican immigration as well as the history of insidious discrimination against Mexican Americans, this community experiences heightened discrimination based upon Mexican American ancestry. Their reality is different and may be harsher than Latinos of white European origin; however, the status of being "Latino" is not a status one can opt out of, as race/ethnic discrimination against Latinos in the U.S. is something one cannot avoid through alternative self-identifications (Romany and Culliton, 2005).

Despite the over-arching, pervasive nature of race/ethnic health disparities, the *Healthcare Equality Act* would be most effective because it would redress more than race/ethnic issues. Certain other types of discrimination are so pervasive that failure to address them along with race/ethnic discrimination would leave many of the nation's 40 million Latinos subject to extreme inequities. In particular, gender discrimination should also be redressed, because the doubly severe lack of access to health experienced by Latinas is likely to be exacerbated by male-centered models or gender-neutral models.

This model works well in the Latino public health field. For example, in order to address the intersectionality of discrimination, LCAT issues popular Fact Sheets in English and Spanish for Latinas, such as *Latinas and Tobacco*, and sponsors and promotes specific programming oriented towards women. Although Latinas smoke less than Latinos, LCAT is concerned that the number of Latina smokers is increasing. Another concern is the targeted marketing of Latinas by big tobacco in magazines oriented towards this group. As reported by Laura Wides-Muñoz of the *Associated Press* on November 17, 2005, *KoolMIX* recently ran an eight-page spread in *Latina* magazine, along with a similar campaign in *Cosmopolitan en Español*, both of which have a young readership including many Latinas who are too young to be sold cigarettes legally. Discriminatory targeted marketing in Spanish is not being sufficiently monitored by the

government. Furthermore, as compared to men, Latinas experience greater health disparities and much less access to smoking prevention and cessation assistance, along with less access to any health care needed due to the damage done by smoking.

The race/ethnic component is also critical. If tobacco control advocates were to call for a generic, mainstream remedy to health damages done by smoking, the #1 cause of preventable death, then such a remedy would not effectively redress the damage done to the Latino community, and it would leave out or leave behind many Latinos (Parity Alliance, 2005). Similarly, because of the way discrimination operates, if advocates were to insist upon remedies that only redress race/ethnic discrimination, many Latinas would be left out or left behind.

The intersectionality approach to understanding Latino community experiences works well to ensure inclusion of other forms of discrimination as well. For example, advocates and policy-makers must take into account age-based health disparities, as the Latino community is the fastest-growing and the youngest, that youth are more susceptible and have less access to health, and that youth must rely upon adults to access health. LCAT studies the situation of Latino youth, and is concerned about increasing adolescent smoking and binge drinking. LCAT is also undertaking new Latino civil rights initiatives to redress the aggressive, discriminatory, targeted marketing of Latino youth by alcohol and tobacco companies. Using a community-based, intersectionality model permits advocates to take into account the real life needs and challenges of Latino youth, whose lives are more complex due to the intersection of age, gender, social status, and race/ethnic factors. Our comprehensive approach also factors in gender, including targeted marketing of Latina adolescents, as discussed above, as well as other forms of targeted marketing praying upon the susceptibilities of male adolescent Latinos. This model also helps better understand and redress the situation of Latino immigrants, of

those with limited English proficiency, and other members of *La Raza* who experience compounded or heightened discrimination based on a number of factors. LCAT believes that this model is the most effective for improving Latino community health, and therefore, LCAT supports public policies that redress the intersectionality of discrimination, without diluting the paramount focus on the pervasive race/ethnic discrimination that affects *all* Latinos.

LCAT, as a member of the *Race Ethnic Health Disparities Coalition* (REHDC) comprised of various race/ethnic advocacy groups, urges policy makers to adopt an intersectionality model to redress health disparities. Experience shows that this approach will be much more effective at redressing the health disparities and lack of access to health in the U.S. today (*See. e.g.*, Robinson, 2005)(discussing reduction of Black-White disparities achieved through comprehensive programs). Members of the REHDC include the *African American Health Alliance, Asian and Pacific Islander American Health Forum, NAACP, National Hispanic Medical Association, National Hispanic Nurses Association, National Medical Association,* and *Physicians for Human Rights,* among other groups.

REHDC and other civil rights coalitions agree that civil rights law needs to be further developed to encompass the reality of race/ethnic communities. Various scholars and advocates have also pointed out that facile definitions of race and ethnicity can complicate, rather than assist, the lives of Latinos and members of other race/ethnic "minority" groups (*See, e.g.*, De Casta, 2003; Edley, 2003; Wu, 2003). At the same time, consistently increasing indicators of race/ethnic health disparities, along with increasing race/ethnic discrimination against Latinos in all facets of life, prove that the reality of race/ethnic discrimination is omnipresent. Protections against race/ethnic discrimination should not be diluted simply because many people of color experience additional forms

of discrimination. Instead, the model proposed in the *Healthcare Equality Act*, which recognizes and would seek to remedy various forms of discrimination, without diluting protections against race/ethnic discrimination, is necessary to end health disparities and meet the public policy goals at hand.

3. <u>Language Access Issues</u>. The *Healthcare Equality Act* supported by LCAT and numerous other civil rights groups directly incorporates the mandates of *Executive Order 13166*, issued on August 11, 2000, in order to implement the protections of the *1964 Civil Rights Act* and ensure against discrimination on the basis of national origin under Title VI of the Act, for persons with limited English proficiency ("LEP persons")(*Healthcare Equality Act*, Sec. 2901). In contrast, the *2004 Closing the Healthcare Gap Act* did not provide any language access protections (CRS, 2004), and it is highly uncertain whether language access will be included at all in the next version of the bill, to be reintroduced in the near future. Providing access to health care for LEP persons is critical to many members of the Latino community; without language access provisions, health disparities will not be resolved and may even be exacerbated for many Latino families, especially the Latino immigrant families described in the introduction of this paper. Many Latinos speak English and in fact, Latino immigrants are learning English at a higher rate than other historical immigrant groups in the United States. Numerous studies have shown that Latino immigrants want to learn English, but are confronted with lack of access to educational opportunities since the cutbacks in *English as a Second Language* (ESL) programs (MALDEF and LULAC, 2004). A comprehensive 2002 *Pew Hispanic Center* survey of the nation's Latinos found that 72% of foreign-born Latinos said that Spanish is their primary language, and only 24% were bilingual. In contrast, 61% of U.S.-born Latinos consider that English is their primary language, and 35% reported being bilingual (Suro, 2002).

It is in the context of accessing health care that most people need to rely upon their first language, as the health care system is complex and health issues are more personal and create more anxiety about communication than in other settings. For those millions of Latinos who are LEP persons, providing access to health care by ensuring adequate language services is absolutely fundamental to redressing health disparities.

Providing language access is also critical to ensuring against prohibited forms of discrimination and thereby remedying health disparities caused by such discrimination. The August 11, 2000 *LEP Guidance* emphasized that: "The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English." Moreover:

> Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Considering that few federal agencies, including the HHS, have fully complied with the basic mandate of the *LEP Guidance*, a legislative mandate is highly recommended. On December 5, 2001, the HHS issued its own *LEP Guidance*, but it has yet to ensure that all HHS programs and recipients of HHS funding "take reasonable steps to ensure meaningful access to their programs and activities by LEP persons." (HHS, 2001, *passim*.). The HHS LEP Guidance also emphasized that: "A recipient/covered entity whose policies, practices or procedures exclude, limit, or have the effect of excluding or limiting, the participation of any LEP person in a federally-assisted program on the basis of national origin may be engaged in discrimination in violation of Title VI;" and that

"the most important step" in ensuring compliance with Title VI by ensuring that LEP persons have meaningful access "is for recipients of Federal financial assistance such as grants, contracts, and subcontracts to provide the language assistance necessary to ensure such access, at no cost to the LEP person." (HHS, 2001, 6). Not all federal health care funding is provided through the HHS, and other relevant federal agencies have yet to even issue their initial LEP assessment and guidance document, as required by *Executive Order 13166*. Therefore, the *Healthcare Equality Act*'s Title A, *Culturally and Linguistically Appropriate Healthcare*, whose purposes are "to improve access to services for persons with limited English proficiency as provided in *Executive Order 13166*," is essential to remedy language-based health disparities and protect against one of the most insidious forms of discrimination against Latinos (Sec. 2901, *Healthcare Equality Act*).

The experience of the LCAT network of 2,500 Latino public health experts, community leaders, advocates and organizations, is that providing information in Spanish is essential to serving the health needs of many members of the Latino community. Therefore, LCAT and other Latino health advocates consistently provide public information, training, access to health care, and advocacy materials in English and Spanish. If programs are needed to address the Latino immigrant population, or the elderly, or the poorest of the community, LCAT provides materials primarily in Spanish, and then may translate them to English as necessary. Public policy makers should take into account this experience and expertise of stakeholders in the health disparities bills being discussed in Congress today. Considering that millions in the Latino community simply do not receive important health information unless it is provided in Spanish, any health disparities bill must provide for language access. As discussed in the HHS *LEP Guidance*, many times, failure to provide language access may be a pretext for

race/ethnic or national origin discrimination, which U.S. law prohibits (HHS, 2005, 4 (section entitled *Case Law*)). For all these reasons, health disparities legislation absolutely must provide for language access to health care for LEP persons. To do otherwise would take America backwards in terms of civil rights protections for our diverse population.

C. Conclusions & Recommendations:

As shown by post-Katrina public opinion polls, the U.S. is at a critical point due to raising awareness of poverty, race/ethnic discrimination, and the importance of public health. As shown by the October 27, 2005, *New California Media* poll, these issues are more salient for African Americans and Latinos. The Latino community's interest in these issues is based on the fact that Latinos suffer disproportionately from health-related disparities.

For the Latino community, the main structural disparities are race/ethnic discrimination, lack of access to immigration status, and language access barriers, among other factors. The actual problems experienced by Latino families, especially immigrant families, must be taken into account in the current post-Katrina public policy debate on health disparities. Otherwise, any sort of legislation designed to remedy health disparities will be grossly ineffective with regard to the Latino community, which is not only the youngest, largest and fastest-growing U.S. "minority" group, but also the group that experiences the harshest health disparities.

This paper analyzed two major health disparities bills being debated in the current Congress. The *Health Disparities Equality and Accountability Act* enjoys wide support among Democratic Congress Members, but little if any Republican support. The *Closing the Healthcare Gap Act of 2004* enjoyed some bipartisan support, but several compromises were made during its negotiation. To be precise, the *Health Disparities*

Equality and Accountability Act provides for three basic, fundamental needs of the Latino community in ways that *Closing the Healthcare Gap Act* did not. These fundamental needs include remedying barriers to health care based on immigration status, which affects about two-thirds of the nation's Latino community. Post-Katrina, immigration status barriers have been exacerbated, making their resolution even more urgent.

The second basic factor causing health disparities for Latinos is race/ethnic discrimination. As the above analysis demonstrated, race/ethnic discrimination is a pervasive root cause of the severe health disparities impacting the Latino community. For example, the fact that Latino citizens are being harassed about their immigration status when they apply for FEMA benefits demonstrates that the status of being "Latino" is the cause of discriminatory treatment. LCAT and its partners in public health coalitions highly recommend that Congress pass legislation to remedy race/ethnic discrimination. Otherwise, any health disparities legislation may not help, and may even harm communities of color.

The final major factor causing health disparities for the Latino community is failure to provide language access. Failure to provide language access can be a pretext for national origin discrimination, and it is nearly always an obstacle to equal access to health care for LEP persons. In order for the entirety of the Latino community to enjoy equal access to federally-funded health benefits, language access must be provided.

Unfortunately, the bipartisan *Closing the Health Care Gap Act of 2004* does not provide for language access, or remedy immigration status barriers to access to health. As discussed above, these serious shortcomings also constitute failures to address the race/ethnic discrimination behind immigration status and language disparities. Moreover, the *Closing the Health Care Gap Act of 2004* would dilute already-scarce programs and

funding designed to redress race/ethnic discrimination, and this is a critical failure for the Latino community.

This paper did not cover all of the health disparities experienced by the Latino community that must be addressed by policy-makers. However, the current policy debates indicate that it is most important to identify and redress the fact that people of color experience serious structural disparities. The post-Katrina public policy debate presents an opportunity to finally redress such structural disparities. Congress should pass health disparities legislation that directly and comprehensively addresses race/ethnic and any other forms of discrimination causing health disparities in a holistic manner, utilizing the concept of the intersectionality of discrimination. This paper demonstrated that the concept of intersectionality mirrors the real world experience of the nation's Latino community and other race/ethnic "minorities." Failure to redress the intersectionality of race/ethnic discrimination with other forms of discrimination will only serve to exacerbate race/ethnic disparities. It would dilute existing civil rights protections, which would be entirely contradictory to the policy goals of health disparities legislation.

In conclusion, the experience of Latino public health advocates demonstrates that using an intersectionality model to directly redress race/ethnic and other forms of discrimination without dilution, is critical to ensure that any health disparities legislation meet its policy goals. For all these reasons, Congress Members from both parties should either modify the *Closing the Health Care Gap Act* as it is currently being renegotiated, or unequivocally support the *Health Care Equality Act*, because the equality-based Act provides for the fundamental needs of the Latino community, whereas the gap-based Act does not. Unless these inequities are resolved, any sort of legislation designed to remedy health disparities will be grossly ineffective.

Bibliography

Sen. Akaka, Daniel, and Rep. Honda, Michael M., 2005. *Health Care Equality and Accountability Act*, S. 1580/H.R., 3561, 109th Congress.

American Baptist Churches v. Thornburgh, 760 F.Supp. 796 (N.D. Calif. 1991).

Broder, Tanya, 2005. Immigrant Eligibility for Public Benefits, American Immigration Lawyers' Association, *Immigration and Nationality Law Handbook* 759.

Central American Resource Center (CARECEN), 2005. *Letter to President Bush Supporting TPS for Guatemalans.*

Congressional Research Service (CRS), 2004. *The Healthcare Equality and Accountability Gap and the Closing the Health Care Gap Act of 2004 (Side-by-Side).*

Rep. John Conyers, Jr., 2000. Statement (against *bracero* programs), *Judiciary Committee Mark-up of H.R. 4548, The Agricultural Opportunities Act*, available at www.house.gov/judiciary_democrats/hr4548markup.htm.

Culliton, Katherine, 2005. Los Derechos Humanos y Derechos Laborales de los Inmigrantes Latinos en los Estados Unidos, *Mexicanos Aquí y Allá ¿Perspectivas Comunas?* Mexico City: Fundación de Solidaridad Mexicana Americana.

De Casta, Kimberly, 2003. Color-Consciousness or Color-Blindness? Risks and Imperatives. Culture, History & Identity, *Color Lines Conference*, Harvard Civil Rights Project, August 30-September 1, 2003.

Department of Health and Human Services (HHS), 2001. *Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*.

Edley, Christopher, Jr., 2003. Black-Brown Relations at a Crossroads. Culture, History & Identity, *Color Lines Conference*, Harvard Civil Rights Project, August 30-September 1, 2003.

Falcón, Angelo, Aguirre-Molina, Marilyn, and Molina, Carlos W., 2001. Latino Health Policy: Beyond Demographic Determinism" Ch. 1, *Health Issues in the Latino Community*.

Federal Emergency Management Agency (FEMA), 2001. *All Who Need Help Should Seek Help Regardless of Immigration Status*, Release No. 1391-27.

Friendly House, et. al. v. Napolitano, Order No. 1515505p (9th Cir., Aug. 9, 2005)(on appeal by plaintiffs).

Fremstad, Shawn, and Cox, Laura, 2004. *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance.* Center on Budget and Policy Priorities, sponsored by Kaiser Family Foundation, available at www.kff.org/medicaid/upload/Covering-New-Americans-A-Review-Of-Federal-And-State-Policies-Related-To-Immigrants-Eligibility-And-Access-To-Publicly-Funded-Health-Insurance-Report/pdf.

Sen. Frist, William H., 2004. *Closing the Health Care Gap Act of 2004*, S. 2091, 108th Congress.

Giachello, Dr. Aida, 2005. Latinas, Smoking Prevention and Cessation. Keynote Presentation, *Latinas, Cáncer y Tabaco*, Nebraska Office of Smoking and Health Conference.

Giachello, Dr. Aida, 1996. Health Outcomes Research on Hispanics/Latinos. *Journal of Medical Systems* 1996: 20(5):235-253.

Department of Health and Human Services (HHS), LEP Guidance, available at www.hhs.gov/ocr/lep/guide.html.

HHS, 1988. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General*.

Huntington, Samuel P., 2004. *Who Are We? Challenges to America's National Identity*. New York: Simon & Schuster.

Inter-American Development Bank, 2005. *Remittances and Development*.

Sen. Edward Kennedy, 1965. *Immigration and Nationality Act of 1965*.

LULAC v. Wilson, 908 F. Supp. 755 (C.D. Cal. 1995).

Mexican American Legal Defense and Educational Fund (MALDEF) and League of United Latin American Citizens (LULAC), 2004. *MALDEF and LULAC Rebuke Samuel Huntington's Theories on Latino Immigrants and Call on America to Reaffirm Its Commitment to Equal Opportunity and Democracy*.

National Hispanic Leadership Agenda (NHLA), 2004. *How the Latino Community's Agenda on Immigration Enforcement and Reform Has Suffered Since 9/11*.

Protect America Now, 2005, www.pan2005.com.

Office of Minority Health (OMH), 2003 and 2004. *National Healthcare Disparities Report*(s), available at www.qualitytools.ahrqu.gov/disparitiesreport.

Parity Alliance, 2005. Amicus Brief. *U.S. v. Phillip Morris*, C.A. No. 99-CV-02496 (GK), (D.D.C. Sept. 12, 2005).

Robinson, Dr. Robert G., 2005. Community Development Model for Public Health Applications: Overview of a Model to Eliminate Population Disparities. *Health Promotion Practice*, 6:3, 338-346.

Romany, Cecilia, and Culliton, Katherine, 2002. The U.N. World Conference Against Racism: A Race-Ethnic and Gender Perspective. *Human Rights Brief*, 9:2, 14-17.

Scherer, Michael, 2005. Scrimmage on the Border, *Mother Jones* 50, July/August 2005.

Southern Poverty Law Center (SPLC), 2005. Arizona Showdown. *Intelligence Report* 118: 16-31.

Suro, Roberto, and Passell, Jeffrey, 2003. *The Rise of the Second Generation: Changing Patterns in Hispanic Population Growth*. Pew Hispanic Center.

Suro, Roberto, *et. al*., 2002. *2002 National Survey of Latinos*. Pew Hispanic Center/Kaiser Family Foundation.

The White House, 2000. Executive Order 13166, *Improving Access to Services for Persons With Limited English Proficiency*.

Wishnie, Michael J., 2004. State and Local Police Enforcement of Immigration Laws. 16 *University of Pennsylvania Journal of Constitutional Law*, 1084, 1086-87.

Wu, Frank, 2003. Conceptualizing the Racial Order in the 21st Century. Culture, History & Identity, *Color Lines Conference*, Harvard Civil Rights Project, August 30-September 1, 2003.

U.S. Commission on Civil Rights, 1980. *The Tarnished Golden Door: Civil Rights Issues in Immigration.*

U.S. Commission on Civil Rights, 1989. *Immigration Reform and Control Act: Assessing the Evaluation Process.*

U.S. Commission on Civil Rights, 2003. *Crossing Borders: The Administration of Justice and Civil Rights Protections in the Immigration and Asylum Context.*

U.S. Congress, 1964. *1964 Civil Rights Act*, 42 U.S.C.A. §2000 *et. al.*

U.S. Congress, 1996. *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* and *Illegal Immigrant Reform and Immigrant Responsibility Act of 1996*, 8 U.S.C. §1621 *et. al.*

# # # # #